



**Texas Department of Insurance**

**Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48  
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645  
512-804-4000 telephone • 512-804-4811 fax • [www.tdi.texas.gov](http://www.tdi.texas.gov)

**MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

**GENERAL INFORMATION**

**Requestor Name and Address**

GRANT MCKKEEVER  
PO BOX 121589  
ARLINGTON TX 76012

**Respondent Name**

ZURICH AMERICAN INSURANCE CO

**Carrier's Austin Representative Box**

Box Number 19

**MFDR Tracking Number**

M4-13-1194-01

**MFDR Date Received**

January 15, 2013

**REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "Dr. Grant McKeever requests Medical Dispute Resolution in pursuant of Rule 133.305 Medical Dispute Resolution in the above referenced patient's case.

These services were requested and prescribed by the Division. The above referenced designated doctor performed the MMI examination and assigned the IR, but he did not perform the range of motion, strength, or sensory testing of the musculoskeletal body are(s), that means he should bill using the appropriate MMI CPT Code 99456- with the component modifier-26. Reimbursement for the examining doctor is 80% of the MAR.."

**Amount in Dispute:** \$300.00

**RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "This is a medical fee dispute concerning a designated doctor evaluation performed on September 10, 2012. Requestor billed \$650.00 under CPT 99456-W5-26 and \$650 under CPT 99456-W5-TC. Carrier issued reimbursements of \$280.00 and \$70.00 respectfully."

**Response Submitted by:** Flahive, Ogden & Latson

**SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 10, 2012	CPT Code 99456-W5-26 and CPT Code 99456-W5-TC	\$300.00	\$300.00

**FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

- 28 Texas Administrative Code §133.307 amended to be effective May 31, 2012, 37 Texas Register 3833, applicable to medical fee dispute resolution requests filed on or after June 1, 2012, sets out the procedures for resolving a medical fee dispute.
- 28 Texas Administrative Code §134.204 sets out the fee guideline for workers' compensation specific services

on or after March 1, 2008.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated October 08, 2012

- W1 – WORKERS’ COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT

Explanation of benefits dated October 16, 2012

- W1 – WORKERS’ COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT

### **Issues**

1. Were the services billed in accordance with 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to reimbursement for the disputed services under 28 Texas Administrative Code §134.204?

### **Findings**

1. Review of the medical bills finds the requestor billed CPT Code 99456-W5-26 in the amount of \$650.00 with one unit and CPT 99456-W5-TC in the amount of \$650.00 with one unit also.

Per 28 Texas Administrative Code 134.204 states:

(j) Maximum Medical Improvement and/or Impairment Rating (MMI/IR) examinations shall be billed and reimbursed as follows

(1) The total MAR for an MMI/IR examination shall be equal to the MMI evaluation reimbursement plus the reimbursement for the body area(s) evaluated for the assignment of an IR. The MMI/IR examination shall include:

(3) The following applies for billing and reimbursement of an MMI evaluation

(C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be \$350

(4) The following applies for billing and reimbursement of an IR evaluation

(C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas

(i) Musculoskeletal body areas are defined as follows:

(I) spine and pelvis;

(II) upper extremities and hands; and,

(III) lower extremities (including feet).

(ii) The MAR for musculoskeletal body areas shall be as follows

(II) If full physical evaluation, with range of motion, is performed:

(-a-) \$300 for the first musculoskeletal body area; and

(-b-) \$150 for each additional musculoskeletal body area and

(iv) If, in accordance with §130.1 of this title (relating to Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment), the examining doctor performs the MMI examination and assigns the IR, but does not perform the range of motion, sensory, or strength testing of the musculoskeletal body area(s), then the examining doctor shall bill using the appropriate MMI CPT code with CPT modifier "26."

Reimbursement shall be 80 percent of the total MAR.

Review of the submitted documentation DWC-32 (Request for Designated Doctor Examination) and DWC-69 (Report of Medical Evaluation) supports an examination requested to address the following issues of Maximum Medical Improvement (MMI) and Impairment Rating (IR) with one body area assigned however the examining doctor did not perform the range of motion used.

Therefore, CPT Code 99456 W5-26 is supported. The Total Mar for CPT Code 99456-W5-26 is \$520.00.

Per Administrative Code 134.204 states:

(j) Maximum Medical Improvement and/or Impairment Rating (MMI/IR) examinations shall be billed and reimbursed as follows

(1) The total MAR for an MMI/IR examination shall be equal to the MMI evaluation reimbursement plus the reimbursement for the body area(s) evaluated for the assignment of an IR. The MMI/IR examination shall include:

(3) The following applies for billing and reimbursement of an MMI evaluation

(C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be \$350

(4) The following applies for billing and reimbursement of an IR evaluation

(C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas

(i) Musculoskeletal body areas are defined as follows:

(I) spine and pelvis;

(II) upper extremities and hands; and,

(III) lower extremities (including feet).

(ii) The MAR for musculoskeletal body areas shall be as follows

(II) If full physical evaluation, with range of motion, is performed:

(-a-) \$300 for the first musculoskeletal body area; and

(-b-) \$150 for each additional musculoskeletal body area and

(v) If a HCP, other than the examining doctor, performs the range of motion, sensory, or strength testing of the musculoskeletal body area(s), then the HCP shall bill using the appropriate MMI CPT code with modifier "TC." In accordance with §130.1 of this title, the HCP must be certified. Reimbursement shall be 20 percent of the total MAR.

Review of the submitted documentation DWC-32 (Request for Designated Doctor Examination) and DWC-69 (Report of Medical Evaluation) supports a examination requested to address Maximum Medical Improvement (MMI) and Impairment Rating (IR) to one body area performed by the technician using range of motion (ROM) method.

Therefore, CPT Code 99456 99456-W5-TC is supported. The Total Mar for CPT Code 99456-W5-TC is \$130.00.

2. The respondent issued payment in the amount of \$350.00. Based upon the documentation submitted, additional reimbursement in the amount of \$300.00 is recommended

**Conclusion**

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due.

***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$300.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
Date

March 07, 2014

## **YOUR RIGHT TO APPEAL**

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**